East Asian Medicine Practitioner License Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

East Asian Medicine Practitioner
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

(This page intentionally left blank.)

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.

☐ **1. Demographic Information:**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name, first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Plan For Consultation, Emergency Transfer And Referral**
Provide your written plan prior to treating any patients and keep a copy on file at your place of business.

☐ **4. Pre-East Asian Medicine (Basic Science) Education:**
Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a sheet of paper. Transcripts must be sent directly to the department.

☐ **5. Certified East Asian Medicine Didactic and Clinical Program:**
List the name and address of East Asian Medicine Didactic and Clinical Program. If you need more space, attach a sheet of paper.

☐ **6. Experience:**
List in date order all professional experience and practice from date of graduation from professional college. If you need more space, attach a sheet of paper.

☐ **7. Other License, Certification, or Registration:**
List all states or jurisdictions, U.S. and foreign, where you have a health care practitioner credential. Please list all active, inactive and expired credentials. If you need more space, attach a sheet of paper.

☐ **8. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **9. Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

☐ **10. Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

License Requirements

☐ **Education Completed Form.** Each course must be listed on the form. It must be completed and sent with the application.

☐ **CPR certification.** A copy of your unexpired Cardio-Pulmonary Resuscitation (CPR) card.

The following require primary source verification. They will only be accepted when mailed directly to the department from the source. These items should not be included with your application. They should be sent directly to the Department of Health, East Asian Medicine Practitioner Credentialing, PO Box 47877, Olympia, WA 98504-7877.

☐ **Official transcript.** The transcripts must be for all Basic Science and East Asian Medicine school/educational programs.

If a graduate of a foreign school, provide a credentialing evaluation report from the American Association of Collegiate Registrars and Admissions Officers (AACRAO). Contact AACRAO at 202.292.9161, ext. 6401.

☐ **Verification of clinical training.** The clinical training form must be completed by the approved East Asian Medicine school verifying completion of your clinical training.

☐ **NCCAOM verification.** Request verification of passing the NCCAOM examinations. The exams must include the Foundations of Oriental Medicine, Acupuncture with Point Location and Biomedicine. Include verification of having taken and passed the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) clean needle technique course. The telephone number for NCCAOM in Jacksonville, Florida is 904.674.2468.

Note: If the NCCAOM examinations were not passed in English, then you need to take the Test of English as a Foreign Language (TOEFL) internet-based (IBT) exam.

☐ **Verification of TOEFL.** You must have written verification of having passed the TOEFL IBT with at least the following scores:

a. 24 on the writing section;

b. 26 on the speaking section;

c. 21 on the reading section; and

d. 18 on the listening comprehension section.

If you wish to be scheduled for this examination or if you want to have verification of your scores sent to this office, contact the TOEFL Registration Office at P.O. Box 6152, Princeton, NJ 08541-6151 or call 609.771.7100. The TOEFL code for Washington State is WA0201.

☐ **Verification of licenses.** You will need to request all U.S. and foreign boards and jurisdictions where you have held a professional license to send verification. We will not accept license copies.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See **WAC 246-12-020(3)**.
- You will receive a courtesy renewal notice if your license and address are kept up to date. Any renewal postmarked or given to the department after midnight on the expiration date is late.

Information regarding the acupuncture program is also available on the **East Asian Medicine Practitioner Program Web site**.

You must provide proof of successful completion of didactic and clinical training courses.

A. Didactic Training—Basic Sciences and East Asian Medicine Sciences

1. Completed over a minimum period of two academic years.
2. 45 quarter credits or 450 hours in the following subjects:
   - Anatomy
   - Physiology
   - Microbiology
   - Biochemistry
   - Pathology
   - Survey of Western Clinical Sciences
   - Hygiene (minimum one credit) (included in Microbiology or Clean Needle Technique Course)
3. 75 quarter credits or 750 hours in East Asian Medicine sciences in the following subjects:
   - Fundamental Principles
   - Diagnosis
   - Pathology
   - Therapeutics
   - Meridians/vessels and points; and
   - Techniques, including electro-acupuncture

B. Clinical Training—East Asian Medicine

1. Includes a minimum of 500 hours of supervised clinical training including no more than 100 hours of observation, which includes case presentation and discussion. At least 400 hours must be patient treatment.
2. Qualified instructors must observe and provide guidance to the student as appropriate. Instructors must be available to provide consultation and assistance to the student for patient treatments. Prior to initiation of each treatment, the instructors must have knowledge of and approve the diagnosis and treatment plan.
3. Patient treatment includes patient intake interview; East Asian Medicine examination and diagnosis; discussion between instructor and student about the proposed diagnosis and treatment plan; applying East Asian Medicine treatment principles and techniques; and charting of patient conditions, evaluative discussions and findings and concluding remarks.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0295010000

East Asian Medicine Practitioner License Application

Please type or print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

Address

City | State | Zip | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City | State | Zip | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # _____ Issue Date_____

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Plan for Consultation, Emergency Transfer and Referral

I certify that prior to treating any patients, I will submit to the Department of Health my written consultation plan and have a copy of the plan on file at my place of business. It will include:

1. The name, license number and telephone number of two licensed consulting primary health care providers.
2. A statement attesting that in an emergency, I will:
   a. Initiate the emergency medical system (EMS) by dialing 911;
   b. Request an ambulance; and
   c. Provide patient support until emergency response arrives.
3. Confirmation from the primary health care providers listed as to their agreement to consult with and accept referred patients.

I further understand that I shall consult with or request a written diagnosis from a primary health care provider if I see a patient with a potentially serious disorder, as identified in WAC 246-803-310, is suspected. If the patient refuses to authorize such consultation or to provide a recent diagnosis, treatment will only continue after the patient signs a written waiver acknowledging the risks associated with the failure to pursue treatment from a primary health care provider.

Applicant's Initials	Date

4. Pre-East Asian Medicine (Basic Science) Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a sheet of paper.

Full name, city and state of schools attended	Degree earned	Attendance	
		Entrance date	Ending Date

5. East Asian Medicine Didactic and Clinical Program

East Asian Medicine Didactic Program

Address

City	State	Zip	County

East Asian Medicine Clinical Program

Address

City	State	Zip	County

6. Experience

In date order, list all your experience. Exclude activities listed under other sections. If you need more space, attach a sheet of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Type of experience or specialty

7. Other License, Certification, or Registration

List all states or jurisdictions, US and foreign, where you have a health care practitioner credential. List all active, inactive and expired credentials. List the credential type and request the state and/or jurisdiction send official verification directly to this office. If you need more space, attach a sheet of paper.

State	Profession	License Type	License		Method of License	Currently Active
			Yr. Issued	Number		No ☐ Yes ☐
						☐ ☐
						☐ ☐
						☐ ☐

8. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

9. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

10. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)

the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

Washington State Department of Health

Education Completed

This form is required of all applicants prior to a license being issued.
Please make copies if more space is required.

Applicant Name _____

Western Science Courses (all courses taken from any school)

Year	Name of school/program	Title of course	Equivalent to this required course	Credits
(Example) 1994	University of Washington	Biology 102	Microbiology	3

East Asian Medicine Education Completed

Year	Name of school/program	Title of course	Equivalent to this required course	Credits
(Example) 1997	Bastyr	East Asian Medicine Theory	Fundamental Principles of East Asian Medicine	5

(This page intentionally left blank.)

Washington State Department of Health
East Asian Medicine Practitioner Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

To the State Board: The individual below is applying for a license as an East Asian Medicine Practitioner in Washington State. Please complete and mail this form directly to the address above. This will assist the department with the review process.

Thank you for your cooperation.

Name of licensee _____

License number _____ Date of issue _____

Expiration date _____

Issued on the basis of _____

State examination _____ National Board _____

Reciprocity/Endorsement from (indicate state) _____

Other (explain) _____

_____

Has licensee's license ever been suspended, revoked or subject to other disciplinary action?

☐ Yes ☐ No

If yes, please explain _____

_____

State Seal

Signature of verifier _____

Title _____

State board _____

Date _____

(This page intentionally left blank.)

Washington State Department of Health
East Asian Medicine Practitioner Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Clinical Training Verification

Applicant's name _____ DOB _____

School or clinic name clinical training received from _____

School or clinic address _____

Training dates: From _____ To _____

I certify that the applicant named above has met the supervised clinical training requirements of **WAC 246-803-230**, consisting of the following:

A minimum of five hundred (500) hours of supervised clinical training including no more than one hundred (100) hours of observation which includes case presentation and discussion. At least four hundred (400) hours must be patient treatment.

1. Qualified instructors must observe and provide guidance to the student as appropriate. Instructors must be qualified to provide instruction in their areas of specialization in East Asian medicine as demonstrated by possession of the following:
   a. Broad and comprehensive training in East Asian medicine; and
   b. Two years of relevant current work experience or teaching experience in East Asian medicine.
2. Instructors must be available within the clinical facility to provide consultation and assistance to the student for patient treatments. Prior to initiation of each treatment, instructors must have knowledge of and approve the diagnosis and treatment plan.
3. Patient treatment includes:
   a. Conducting a patient intake interview concerning the patient's past and present medical history.
   b. Performing East Asian medicine examination and diagnosis.
   c. Discussion between the instructor and the student concerning the proposed diagnosis and treatment plan.
   d. Applying East Asian medicine treatment principles and techniques.
   e. Charting of patient conditions, evaluative discussions and findings, and concluding remarks.

Approved program officer signature _____

Date _____

School Seal

(This page intentionally left blank.)

RCW/WAC and On-line Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements..... WAC 246-12

East Asian Medicine Practitioner RCW ..... RCW 18.06

East Asian Medicine Practitioner WAC ..... WAC 246.803

On-Line

AIDS Training Resources ..... Reference Page

East Asian Medicine Practitioner Program ..... Web Page

NCCAOM..... http://www.nccaom.org

TOEFL ..... http://www.ets.org